Appendix A: Healthy Connections

A.1 Healthy Connections

A.1.1 Overview

Healthy Connections (HC) is the Idaho Medicaid program for coordinated or managed care.

The goals of Healthy Connections are to:

- ensure access to healthcare
- provide health education
- promote continuity of care
- strengthen the physician/patient relationship
- achieve healthy outcomes for clients
- achieve cost efficiencies for the Idaho Medicaid program

The HC program is a Primary Care Case Management (PCCM) model of managed care. Health care providers who participate in the HC program are known as PCPs.

HC helps Medicaid clients receive the care they need, when they need it, and at the appropriate place. The assurance of a familiar, consistent doctor/patient relationship creates a "medical home".

In 2002, Healthy Connections became a mandatory program. Client enrollment in the program is required in the majority of counties statewide.

A.1.2 HC Provider Agreement

A Coordinated Care provider agreement must be signed by the provider to enroll in Healthy Connections; this is in addition to the Medicaid provider agreement. Coordinated Care provider agreements are available from the Regional Health Resources Coordinator (HRC).

PCPs are required to furnish proof of medical liability insurance to DHW as a condition of program participation. This is typically accomplished by mailing a Certificate of Insurance to Healthy Connections on an annual basis. PCPs are also to report to Healthy Connections immediately when providers either join or leave their practice.

A.1.2.1 HC Provider Referral Number

When a provider enrolls with the HC program, the provider receives an additional Medicaid provider number to use as a referral number. This number is given in conjunction with the PCP's orders when making a referral to another provider for services. Providers receiving referrals must use the referral number on claims to be reimbursed for services. See section **A.1.4** for more information on referral requirements.

A.1.3 Client Enrollment/Disenrollment

Medicaid clients who enroll in Healthy Connections choose a primary care provider in one of two ways:

1. from a list of participating providers provided by Regional HRCs; or
2. they may indicate their PCP of choice on an Application for Assistance when they apply for medical assistance

Each qualified family member will need to choose his or her own PCP. Family members are not required to choose the same PCP. If a client wants to participate in Healthy Connections but requires assistance in choosing a primary care provider, the regional HRC can provide information regarding participating providers from which the client may choose.

Medicaid clients **not** enrolled in the Healthy Connections Program include those who:

1. Reside either in a Nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
2. Are eligible only as Qualified Medicare Beneficiary (QMB)
3. Have been placed on lock-in with a provider

In a **mandatory participation** area, a client is first asked to choose a provider. If after 10 days the client does not choose a provider, the HRC will assign the client to a provider/practice according to the rotational schedule agreed to by the PCPs. When the Health Resources Coordinator is able to establish a current relationship with a provider through claims history, the individual will be enrolled with said provider.

A client may be **exempt** from mandatory enrollment in Healthy Connections for the following reasons:

- Has a verifiable pre-existing relationship with a non-participating primary care physician or clinic
- Has incompatible third party liability
- The client wished to obtain OB services from an OB specialist during pregnancy and an HC OB is not available
- Travel is more than 30 miles or 30 minutes to obtain primary care services from a HC PCP and there is a non-Healthy Connections provider closer
- Client is on Medicaid Lock-in status

Enrollment in Healthy Connections always begins the first day of the month. The client receives written notice advising him/her of the name, phone number and address of his/her Primary Care Provider.

A.1.3.1 Client's Requested Disenrollment

Clients may request a change in their provider by notifying the **Health Resources Coordinator (HRC)** no later than the 20th of any month. The change will be effective the first day of the following month. The most common reasons a client chooses to disenroll are:

- Moved to a closer PCP within the service area
- Moved to another county
- Pregnancy ended
- Decided they want to see another PCP

A.1.3.2 Provider Requested Disenrollment

Providers **may not** request disenrollment of a client from their practice because of any of the following:

- a change in the enrollee's health status

- the enrollee's utilization of medical services
- diminished mental capacity
- uncooperative or disruptive behavior resulting from his/her special needs, except where his/her continued enrollment with the PCP seriously impairs the PCP's ability to furnish services either to the enrollee or other enrollees (patients)

The provider **may** request disenrollment for the following reasons by providing notification to the client and the HRC at least 30 days prior to the requested disenrollment date. All disenrollments will be dated the first of the next month after the thirty days have elapsed:

- The enrollee fails to follow the treatment plan
- The enrollee misses appointments without notifying the provider (missed appointment policies for Medicaid patients must be the same as for all other patients)
- The enrollee/PCP relationship is not mutually acceptable (for instance, disruptive or uncooperative behavior not due to the enrollee's special needs)
- The enrollee's condition would be better treated by another provider

Any requests for disenrollment other than those listed above must be approved by the HRC prior to notifying the enrollee.

A.1.4 Client Referrals

A.1.4.1 Overview

If a HC provider determines that specialized services are necessary, the PCP refers the client to a specialist for Medicaid covered services. Medicaid will pay for covered services received from another Idaho Medicaid provider with a referral from the HC PCP. All services requiring a HC referral that are rendered without a referral are considered non-covered services and will **not** be paid by the Medicaid program.

Note: In order to bill a Medicaid client for non-covered services, the provider rendering the non-covered services must advise the client prior to provision of such services that he/she (the Medicaid client) will be responsible for the bill. Providers may not balance-bill clients for balances after Medicaid has paid.

A.1.4.2 Referral Requirements

PCPs are required to make referrals for medically necessary services **not** provided by the PCP. The Department defines medical necessity for some services. Most common services that have Medicaid-defined medical necessity criteria are:

- Case Management (Service Coordination)
- Developmental Disabilities Services
- Psychosocial Rehabilitation
- Private Duty Nursing
- Home and Community Based Waiver Services

In counties where participation is mandatory, PCPs are required to provide interim referrals for "ongoing" services that a client may be receiving when the client is assigned to the PCP by DHW but hasn't been seen by the PCP. The PCP must give the client a reasonable amount of time to make an appointment to request a long-term referral.

A referral is a doctor's order for services. HC PCPs can make a referral for a patient by:

- Filling out a Department referral form and giving it to the patient to take to the specialist or sending it directly to the specialist
- Ordering services on a prescription pad
- Calling orders to the specialist

The details of the order are to be documented in the patient's permanent record by both the referring provider and the provider to whom the referral was made. The record should include:

- Who made the referral
- Date of referral
- Scope of services to be provided (including authorization for the receiving providers to use the PCP's referral number to refer the Client to additional, related ancillary services)
- Referral number (for billing purposes)
- Duration of the referral

The scope of services authorized by a referral is determined by the PCP and defines the limitations of the referral. The following are examples:

- Number of visits authorized (i.e., 10 physical therapy visits)
- Time limited (i.e., treat for 3 months)
- Diagnosis or condition related (i.e., treat for developmental delay)

When an individual changes providers, the HC provider of record may give a "transfer of care" referral to the new provider until the Medicaid system changes can be made. This will facilitate services provided by the new provider.

Questions regarding the scope of a referral should be directed to the PCP. At a minimum, referrals for "on-going" services should be renewed by the PCP annually.

Specialists or providers who receive HC PCP referrals are to report findings/progress back to the PCP unless the PCP indicates he/she does not want to receive such feedback.

A.1.4.3 Three-way Referrals

A HC PCP **may** authorize the specialist receiving a referral to order additional services on behalf of the PCP. For example, a referral to diagnose and treat authorizes the specialist to order tests (i.e., lab, x-ray, etc.) to accomplish diagnosis. In these cases, the specialist is to forward the referral information (including the referral number) to the appropriate service providers.

A.1.4.4 Referrals To The Department

Developmental Disabilities and Mental Health services delivered under a plan of care are authorized by the PCP via referral to develop the plan of care. DHW staff (or designees overseeing service delivery) are authorized to forward appropriate referral information to the various providers of service indicated in the approved plan of care.

A.1.4.5 Retroactive Referrals

Making a referral for services that have already been rendered by another provider is at the discretion of the PCP. If the PCP would have given the referral had it been requested

prior to the provision of the service (such as in the case of medically necessary services **not** provided by the PCP), he/she may give the referral retroactively.

A.1.4.6 Documentation of Referrals

Both the PCP and the provider being referred to must document the specifics of the referral in the client file. If the PCP has completed a referral form, a copy of the form should reside in the patient's file in both providers' offices. If another form of physician order or referral was used, such as a phone call or standing order, this information is also required to be in the patient's files and should include specifics of the referral or physician order.

Use of a PCP's Healthy Connections provider number indicates that the billing provider has obtained and documented the referral in the client's record. **Using a referral number without obtaining a referral is considered fraudulent.**

Denials for HC Referral

Claims submitted for services rendered to a PCP's own HC enrollees should never deny because they lack a HC referral (EOB 010 or 011). This type of denial typically happens when the PCP has not reported that a new provider has joined the clinic. **PCPs should contact EDS immediately if they are having trouble billing for their own patients.**

A.1.5 Services That Do Not Require a PCP Referral

Audiology Services: Performed in the office of a certified audiologist. Audiology basic testing requires a physician's order not necessarily from the PCP.

Immunizations: Immunizations do not require a referral when they do not require an office visit. Specialty physicians/providers administering immunizations are asked to provide the client's PCP with immunization records to assure continuity of care and avoid duplication of services.

Chiropractic Services: Performed in the office. Medicaid will pay for a total of twenty-four (24) manipulation visits during any calendar year for remedial care by a chiropractor but only for treatment involving manipulation of the spine to correct a subluxation condition. (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.)

Dental Services: Procedures performed in the dental office. Procedures performed in an inpatient-outpatient hospital setting or ambulatory surgical center setting may require a PA and a referral from the PCP for the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician, and lab work. (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan .)

Emergency Department: Services provided in an Emergency Department (ED) of a hospital.

Family Planning Services: Provided by district health departments or other agencies providing counseling and supplies to prevent pregnancy.

Flu Shots: (not requiring an office visit).

Indian Health Clinic Services: Services for individuals eligible for Indian Health Services.

Long Term Care: Nursing Facility, Intermediate Care Facility for the Mentally Retarded (ICF/MR) NOTE: Long term care services are only covered for Medicaid Enhanced Plan participants.

Personal Care Services (PCS) and PCS Service Coordination Coordination - NOTE: Private Duty Nursing, Nursing Services DD & ISSH Waivers and Supervising Registered Nurse (PCS) are only covered for Medicaid Enhanced Plan participants.

Pharmacy Services: For prescription drugs only. DME provided by pharmacies **always** requires a referral and **sometimes** requires prior authorization.

Podiatry Services: Performed in the office. Procedures performed in an inpatient or outpatient hospital or ambulatory surgery center setting require a referral from the PCP for the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician, and lab work. (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.)

School District Services: Includes all health related services provided by a school district under an Individual Education Plan (IEP). (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.)

Screening Mammography: Limited to one (1) per calendar year for women age 40 and older.

Tests and Treatment for Sexually Transmitted Disease Testing

Transportation: Non-Emergent, medical transportation to and from covered medical services if no other means are available. **(On dates of service prior to 7/1/2006, this was not a covered service for clients formerly enrolled as CHIP-B clients).** Non-Medical waiver transportation is only covered for Enhanced Plan participants.

Vision Services: Performed in the offices of ophthalmologists and optometrists, including eyeglasses. However, procedures performed in an inpatient or outpatient hospital or ambulatory surgery center setting require a referral from the PCP for the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician, and lab work.

Waiver Services for the Aged and Disabled/Traumatic Brain Injured
Note: Waiver Services for the Aged and Disabled and Traumatic Brain Injured are only covered for Medicaid Enhanced Plan participants.

A.1.6 Services that Require a PCP Referral

The following services require referral by the HC provider:

- All physician and mid-level services not provided by the enrollee's PCP and not delivered in an Emergency Department
- Ambulatory Surgical Center Services
- Developmental Disabilities Agency Services: the HC PCP may refer the client to the Regional ACCESS Unit for evaluation, plan development, service coordination, and services for special needs adults and children with developmental disabilities. (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.) **Note:** Developmental Disability services for participants enrolled in the Medicaid Basic Plan is limited to only diagnostic and evaluation procedures. Participants must be enrolled in the Medicaid Enhanced plan in order to be eligible for additional developmental disability services.
- Developmental Disabilities Service Coordination: for individuals 21 years of age or older (requires prior authorization through Regional Medicaid Services [RMS]). (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients.) **Note:** Service Coordination for

participants enrolled in the Medicaid Basic Plan is limited to only diagnostic and evaluation procedures. Participants must be enrolled in the Medicaid Enhanced plan in order to be eligible for additional service coordination services.

- Diagnostic Screening Clinic Services: medical social service visits to clinics which coordinate treatment between physicians and other medical professionals for clients who are diagnosed with cerebral palsy, myelomeningitis, or other neurological diseases. (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.)
- Durable Medical Equipment and Supplies (DME): some equipment and supplies require prior authorization. (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.) **Note:** Waivered DME services are only covered for participants enrolled in the Medicaid Enhanced Plan.
- EPSDT: for children under the age of 21 to include history and physical exams. Also includes services to children with special health needs that are not available to adults such as, but not limited to, private duty nursing (which requires prior authorization from Regional Medicaid Services [RMS]). (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.)
- EPSDT Service Coordination: for individuals under the age of 21 requires prior authorization through local ACCESS Unit. (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.)
- Home and Community Based Services: requires prior authorization from the Regional Medicaid Services (RMS). (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are only covered for participants in the Medicaid Enhanced Plan)
- Home Health Services: (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.)
- Hospice Services: (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are only covered for participants in the Medicaid Enhanced Plan.)
- Hospital Services: both inpatient and outpatient services (some inpatient stays require prior authorization through QUALIS Health).
- Laboratory and Radiological Services
- Mental Health Clinic Services: **Note:** Medicaid Basic Plan participants are limited to twenty-six (26) services for all non-inpatient Mental Health services combined.
- Mentally Ill Service Coordination: for individuals 18 years of age or older (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan. **Note:** Medicaid Basic Plan participants are limited to twenty-six (26) services for all non-inpatient Mental Health services combined.
- Oxygen and Related Services: (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.)

- Physical Therapy: (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.)
- Pregnancy: special services related to pregnancy
- Prosthetic and Orthotic Services: **some** items require prior authorization but **all** items require a PCP referral. (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are covered for participants in the Medicaid Enhanced Plan and the Medicaid Basic Plan.)
- Psycho-Social Rehabilitation Services: (On dates of service prior to 7/1/2006, this is not a covered service for participants enrolled as CHIP-B clients. These services are only covered for participants in the Medicaid Enhanced Plan.)
- **Waiver services for individuals with a developmental disability.**
  Note: Waiver Services for the Aged and Disabled and Traumatic Brain Injured are only covered for Medicaid Enhanced Plan participants.

A.1.7 Prior Authorization

In addition to a HC referral, some services also require prior authorization. Prior authorization numbers **must** be included on the claim or the authorized service will be denied.

A.1.8 Payment

In addition to payment for services rendered, PCPs enrolled in the HC program are paid a monthly case management fee of $3.50 per month for each enrolled client. This monthly case management fee is based upon the number of HC Medicaid clients enrolled in the practice during a calendar month regardless of whether or not the client is seen during that month.

The case management fee payment is automatically generated to PCPs the first pay cycle of each month. Case management fees are included in a separate remittance advice (RA) named Case Maintenance Fee, and mailed separate from the weekly RA.

All other covered services provided for a Healthy Connections Medicaid client are billed to EDS using the physician's Medicaid provider number. See the *Idaho Medicaid Provider Handbook* for physicians for more information on billing for medical services.

A.1.8.1 Rosters

A roster of enrollees, which lists all new, ongoing, and disenrolled HC clients, is generated and mailed to PCPs each month. Clients listed under the Medicaid or SCHIP sections of the roster could be enrolled in either a full or limited benefit plan.

A.1.8.2 HC PCCM Provider Enrollee Roster Field Descriptions

Report Field	Description
PAGE	Page number for reports
RUN DATE	The date and time for reporting run time.
PERIOD	From date in MM/DD/CCYY format
THRU	To date for reports in MM/DD/CCYY format.
COUNTY	Code identifying the county in which a client resides.
REGION	Code indicating a geographic or geopolitical district of the state.
PROVIDER NUMBER	Provider's Idaho Medicaid number.
SL	Location where the provider rendered services.
PROVIDER NAME	First name of a Medicaid provider.
NONE	Middle initial of Medicaid provider.
NONE	Last name of a Medicaid provider.
NONE	Suffix for the provider's name (Jr, Sr, etc.).
MID	Client's Idaho Medicaid identification number (MID).
NAME	Last name of the client.
NONE	First name of the person.
NONE	Middle initial of the client.
DOB	Date of birth of the client.
PCP	Provider's Idaho Medicaid number.
SL	Service location where the provider rendered services.
START DATE	Date the client began HC enrollment.
END DATE	Date the client ended HC enrollment.
TOTAL NEW	Total number of new enrollments for a provider.
TOTAL ONGOING ENROLLEES	Total number of enrollments for a provider.
TOTAL DISENROLLMENT	Total number of disenrollments for a provider.
CURRENT ENROLLMENT	Current number of clients under the care of a HC provider.

A.1.8.3 Sample HC PCCM Provider Enrollee Roster

HCKR250 IDAHO MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE 1
RUN DATE: 02/27/2004 04:16 HC PCCM PROVIDER ENROLLEE ROSTER PERIOD: 03/01/2004 THRU: 03/31/2004
COUNTY: 00
REGION: 01

PROVIDER NUMBER: 1234567 SL: 00 PROVIDER NAME: PRESIDENTIAL PRIMARY HEALTH CARE

MID	NAME		DOB	PCP	SL	START DATE	END DATE
NEW ENROLLEES - MEDICAID							
90000000100	ADAMS	JOHN	Q	02/20/1938		03/01/2004	12/31/2382
90000003100	ARTHUR	ELLEN	R	05/29/1968		03/01/2004	12/31/2382
90000003500	CLEVELAND	GROVER	L	01/12/1948		03/01/2004	12/31/2382
ONGOING ENROLLEES - MEDICAID							
90000005200	BUCHANAN	JAMES	L	01/14/1948		03/01/2004	12/31/2382
90000004400	COOLIDGE	CALVIN	R	12/24/1959		03/01/2004	12/31/2382
90000000900	MONROE JAMES		R	10/21/1989		03/01/2004	12/31/2382
DISENROLLMENT - MEDICAID							
90000001400	EISENHOWER	DWIGHT	R	11/21/1989		03/01/2004	12/31/2382
90000009900	MCKINLEY	IDA	R	10/02/1972		03/01/2004	12/31/2382
NEW ENROLLEES - SCHIP							
90000006500	JEFFERSON	THOMAS	L	01/12/1995		03/01/2004	12/31/2382
90000000400	LINCOLN	MARY	R	11/21/1989		03/01/2004	12/31/2382
90000005900	WILSON	WOODROW	R	10/02/1992		03/01/2004	12/31/2382
ONGOING ENROLLEES - SCHIP							
90000005100	FILMORE	ABIGAIL	R	10/02/1992		03/01/2004	12/31/2382
90000009800	FORD	BETTY	T	05/29/1998		03/01/2004	12/31/2382
90000000500	GARFIELD	JAMES	L	01/12/1998		03/01/2004	12/31/2382
DISENROLLMENT - SCHIP							
90000000900	MONROE	JAMES	R	11/21/1999		03/01/2004	12/31/2382
90000005100	WASHINGTON	MARTHA	R	10/02/1992		03/01/2004	12/31/2382

TOTAL NEW 6 TOTAL ONGOING ENROLLEES 6 TOTAL DISENROLLMENT 4 CURRENT ENROLLMENT 12

A.1.8.4 Case Maintenance Fee RA Field Descriptions

Field	Description
PROV	The provider's Healthy Connections referral number.
RA NUM	This field indicates the number of the RA for the provider for the current financial cycle.
RA TITLE	This RA page is titled: Case Maintenance Fee
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
NUM OF PAID CLAIMS CURRENT	Not used for this report.
NUM OF PAID CLAIMS YEAR-TO-DATE	Not used for this report.
NUM OF DENIED CLAIMS CURRENT	Not used for this report.
NUM OF DENIED CLAIMS YEAR-TO-DATE	Not used for this report.
NUM OF PENDED CLAIMS CURRENT	Not used for this report.
NUM OF PENDED CLAIMS YEAR-TO-DATE	Not used for this report.
NUM OF ADJUSTED CLAIMS CURRENT	Not used for this report.
NUM OF ADJUSTED CLAIMS YEAR-TO-DATE	Not used for this report.
NUM OF VOIDED CLAIMS CURRENT	Not used for this report.
NUM OF VOIDED CLAIMS YEAR-TO-DATE	Not used for this report.
NUM OF CASE MAINTENANCE FEE CLAIMS CURRENT	Not used for this report after February 29, 2004.
NUM OF CASE MAINTENANCE FEE CLAIMS YEAR-TO-DATE	This field indicates the total number of case maintenance fee claims processed for the current year before March 1, 2004. This field will be "0" after December 31, 2004.
CLAIMS PAID AMT CURRENT	Not used for this report.
CLAIMS PAID AMT YEAR-TO-DATE	Not used for this report.
CASE MAINTENANCE FEE PAID AMT CURRENT	Not used for this report.
CASE MAINTENANCE FEE PAID AMT YEAR-TO-DATE	This field indicates the amount paid for case maintenance fee claims processed for the current year before March 1, 2004. This field will be 0.00 after December 31, 2004.
INCREASE DUE TO CLAIM ADJUSTMENTS CURRENT	Not used for this report.
INCREASE DUE TO CLAIM ADJUSTMENTS YEAR-TO-DATE	Not used for this report.

Field	Description
NON-CLAIM PAYOUT AMOUNT CURRENT	This field indicates the amount paid for case maintenance fees (Healthy Connections) during the past week.
NON-CLAIM PAYOUT AMOUNT YEAR-TO-DATE	This field indicates the dollar amount paid for case maintenance fees (Healthy Connections) during the current calendar year. This amount equals the total of the non-claim specific payout amount fields on each RA during the current calendar year.
RECOUPMENT AMOUNT WITHHELD CURRENT	Not used for this report.
RECOUPMENT AMOUNT WITHHELD YEAR-TO-DATE	Not used for this report.
AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS CURRENT	Not used for this report.
AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS YEAR-TO-DATE	Not used for this report.
LIEN, PENALTY, AND INTEREST WITHHELD CURRENT	Not used for this report.
LIEN, PENALTY, AND INTEREST WITHHELD YEAR-TO-DATE	Not used for this report.
TOTAL WARRANT PAYMENT AMOUNT CURRENT	This field indicates the total dollar amount paid for Healthy Connections case maintenance fees processed for the past week.
TOTAL WARRANT PAYMENT AMOUNT YEAR-TO-DATE	This field indicates the total dollar amount paid for Healthy Connections case maintenance fees and financial transactions processed during the current calendar year. After 2004, this amount will only include non-claim payouts for Healthy Connections.
NET EARNINGS CURRENT	This field indicates the net earnings for the past week.
NET EARNINGS YEAR-TO-DATE	This field indicates the net earnings for the current calendar year. This amount equals the total net earnings on each RA for the calendar year.
REFUNDS AND RETURNED WARRANTS CURRENT	Not used for this report.
REFUNDS AND RETURNED WARRANTS YEAR-TO-DATE	Not used for this report.
OTHER ADJUSTMENTS CURRENT	Not used for this report.
OTHER ADJUSTMENTS YEAR-TO-DATE	Not used for this report.
TOTAL TAXABLE EARNINGS CURRENT	This field indicates the net earnings for the provider for the past week.
TOTAL TAXABLE EARNINGS YEAR-TO-DATE	This field indicates the total net earnings for the current calendar year. This amount equals the total of all total taxable earnings on each RA during the current calendar year.
EOB CODES	Not used for this report.
EOB MESSAGES	Not used for this report.

A.1.8.5 Sample Case Maintenance Fee RA

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PROV: 1234567                                IDAHO MEDICAID REMITTANCE ADVICE                          RA NUM: 8845621546
SEQ NO:     1                                      CASE MAINTENANCE FEE                               PAGE NUM:      5
                                                    RA DATE 03/31/2004

F I N A N C I A L  I T E M S
-------------------------------------------------------------------------------------------------------------------------------
                CLIENT LAST NAME     CLIENT FIRST NAME
   A/L NUM            CCN           MID            ICN         HVER DNUM    TXN DATE     ORIG AMT      TXN AMT       BAL AMT   RSN CODE

751997205001000 701997205001000  7654321    201997128131000  01   01     06/23/2004     788.45       788.45          0.00       65

NET IMPACT OF FINANCIAL ITEMS:          994.00

*** FINANCIAL REASON CODES ***

  126   PROVIDER - PAYOUT HMO

                                                                          CURRENT              YEAR - TO - DATE
** COUNTS **
                      NUM OF PAID CLAIMS                                        0                            0
                      NUM OF DENIED CLAIMS                                      0                            0
                      NUM OF PENDED CLAIMS                                      0                            0
                      NUM OF ADJUSTED CLAIMS                                    0                            0
                      NUM OF VOIDED CLAIMS                                      0                            0
                      NUM OF CASE MAINTENANCE FEE CLAIMS                        0                          531

** WARRANT DATA **
                      CLAIMS PAID AMOUNT                                     0.00                         0.00
                      CASE MAINTENANCE FEE PAID AMOUNT                       0.00                     1,858.50
                      INCREASE DUE TO CLAIM ADJUSTMENTS                      0.00                         0.00
                      NON-CLAIM PAYOUT AMOUNT                              994.00                       994.00

                      RECOUPEMENT AMOUNT WITHHELD                            0.00                         0.00
                      AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS               0.00                         0.00
                      LIEN, PENALTY AND INTEREST WITHHELD                    0.00                         0.00

                      *TOTAL WARRANT PAYMENT AMOUNT                        994.00                     2,852.50

** EARNINGS DATA **
                      NET EARNINGS (INCLUDES LIEN, PENALTY AND             994.00                     2,852.50
                                    INTEREST WITHHELD)
                      REFUNDS / RETURNED WARRANTS                            0.00                         0.00

                      OTHER ADJUSTMENTS                                      0.00                         0.00

                      TOTAL TAXABLE EARNINGS                               994.00                     2,852.50

*NOTE: IF TAXABLE SERVICES WERE PROVIDED YOUR ACTUAL PAYMENT AMOUNT MAY NOT MATCH
       THE TOTAL WARRANT PAYMENT AMOUNT.

** MESSAGE CODES **

   000   ** NO EOBS THIS RUN **
                                                  * *  END OF REPORT  8 8 8
```